Health Care Financing Notes

Medicare: Use of Skilled Nursing Facilities, 1976-1977

Published by the Health Care Financing Administration

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Health Care Financing Notes are published periodically by the Health Care Financing Administration's Office of Research, Demonstrations, and Statistics.

The Health Care Financing Administration was established in March 1977 to combine HEW's health financing and quality assurance programs into a single agency. HCFA is responsible for the operation of the Medicare and Medicaid programs, the PSRO program, Federal survey and certification efforts, and a variety of health care quality assurance activities.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 45 million aged, disabled, and poor Americans. HCFA is committed to making beneficiaries aware of the services for which they are eligible, promoting the accessibility of those services and ensuring that HCFA policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORDS also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. In addition, ORDS monitors national health care expenditures and prices and provides actuarial analyses on the costs of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

The purpose of the ***Health Care Financing Notes*** is to provide the public with descriptive program data or information as soon as it becomes available. Data is presented here in a brief, concise format. Frequently a more comprehensive analysis of the data may be available at a later time in one of the Health Care Financing Administration's other publications.

Medicare: Use of Skilled Nursing Facilities, 1976

This Note presents information on the use of skilled nursing facility (SNF) benefits under Medicare. Longitudinal data on the number of covered discharges, covered days of care, covered charges, and the amounts reimbursed by Medicare on behalf of aged and disabled beneficiaries is published through 1977. Data by State of residence for aged beneficiaries in 1976 (the latest year this data is available) is provided for the first time. State data is shown only for the aged beneficiaries since they accounted for about 96 percent of the total amount reimbursed by Medicare for SNF services in 1976.

On January 1, 1967, as part of the Medicare program, Hospital Insurance (HI) beneficiaries aged 65 years and over became eligible for post-hospital care benefits in participating extended care facilities (now refered to as skilled nursing facilities—SNF's). Effective July 1, 1973, these benefits were extended to persons under 65 years of age who were entitled to cash benefits for not less than 24 consecutive months under the disability insurance program and to persons with end-stage renal disease (ESRD).

The SNF benefit was intended by Congress to provide a less costly alternative to inpatient hospital care for those patients who still required institutional skilled nursing care but not the intensity of medical services provided in a hospital.

Highlights of the data follow:

Use and Cost of Skilled Nursing Facilities, 1969-1977

Aged

- Covered SNF discharges of aged HI beneficiaries dropped from 368,000 in 1969 to 277,000 in 1970 to a low of 218,000 discharged in 1972[1]. This descrease was due to issuance in 1969 of more precise level of care regulations for SNF's (Table 1).

- Covered discharges for aged SNF beneficiaries rose to 263,000 in 1974 and has remained near that level through 1977. This occurred as a result of 1972 Social Security Amendments which established a uniform level of care criteria for SNF benefits under the Medicare and Medicaid programs and tended to liberalize the coverage of SNF services under Medicare.[2]

- Correspondingly, covered days of care dropped from 14.5 million in 1969 to 5.8 million in 1972. In 1974 covered days of care increased to 7.2 million and has remained near that level through 1977.

- The average number of covered days of care per aged SNF discharge dropped from 39.3 days in 1969 to 26.8 in 1972; the average in 1977 was 27.4 days.

- Reimbursements for SNF services followed a similar pattern to the utilization of those services. Reimbursements of $277 million in 1969 dropped to a low of $141 million in 1972 and then, due primarily to cost inflation, rose to $244 million in 1977.

- The average reimbursement per aged SNF discharge dropped from $754 in 1969 to $646 in 1972 and then increased to a high of $935 in 1977.

Use and Cost of Skilled Nursing Facilities, 1974-77

Disabled

- From 1974 (the first full year that disabled beneficiaries were covered under Medicare) to 1977, the number of covered discharges increased from 8,010 to 8,864 (Table 1).

- The number of covered days of care increased from 216,000 in 1974 to 249,000 in 1977; the average number of covered days of care per discharge was 27.0 days in 1974 and 28.1 days in 1977.

- Amounts reimbursed by Medicare rose from $6.7 million in 1974 to $9.8 million in 1977. The mean reimbursement per discharge rose from $833 in 1974 to $1,105 in 1977. The mean reimbursement per day rose from $30 to $39.

Prepared by Charles Helbing, Office of Research, Demonstrations, and Statistics, Health Care Financing Administration. Computer software was prepared by Betty Gunn and Vikki Latta.

[1]For a detailed presentation of the administrative and legislative developments affecting SNF benefits between 1969 and 1973, see George S. Chulis, "Medicare Use of SNF Services 1969-73," HI-75, Social Security Administration (SSA), Office of Research and Statistics, February 2, 1977.

[2]For a detailed description of the SNF level of care provisions, see Robert W. Ball, "Social Security Amendments of 1972: Summary and Legislative History," Social Security Bulletin, March 1973.

- Although there has been no notable difference between the disabled and the aged in the number of covered days per discharge, the covered charges incurred and the amounts reimbursed per day and per discharge have been consistently higher for the disabled.

Use and Cost of Skilled Nursing Facility Services by State of Residence, 1976

Aged

- Among the 50 States, the use of SNF services by the aged varied substantially in 1976. For example, in Alaska there were only two participating SNFs which provided skilled nursing care services to only 19 discharges. In contrast, California accounted for over 43,100 discharges, or almost 17 percent of all SNF discharges. New York accounted for nearly 21,400 discharges, or about 8 percent of all SNF discharges (Table 2).

- Among the 50 States, the covered length of stay per discharge ranged from 18.8 days in Colorado to 35.8 days in Delaware. Regionally, the average covered length of stay in the West (20.3days) was about 8 to 9 days less than in the other regions.

- Among the 50 States, the average reimbursement per discharge ranged from $386 in Wyoming to $1,417 in Massachusetts; the average reimbursement per day ranged from $16 in South Carolina to $46 per day in Massachusetts.

- Among the four U.S. Census regions, the average reimbursement per discharge ranged from $711 in the West to $1,045 in the Northeast. The average reimbursement per day ranged from $28 in the South to $36 in the Northeast.

Sources and Limitations of the Data

Data published in this report are derived from a 100-percent count of billing forms submitted by participating SNFs for Medicare beneficiaries receiving reimbursable inpatient skilled nursing services. Information from the billing forms is matched to the Health Insurance Entitlement master file to obtain demographic characteristics of the beneficiary. This information is also matched to the Provider of Services master file to obtain characteristics of the SNF.

Data presented in this report are based on discharge records processed and recorded as of June 1978. As a result, the figures recorded in recent years are not as complete as those for earlier years. The 1977 SNF data shown in Table 1 is "preliminary" since the figures shown were inflated by 5 percent to reflect discharge records that had not been processed as of June 1978.

This report excludes those bill records for SNF services which omit a record of discharge and those SNF discharge records not reporting at least 1 day of covered care under Medicare.

The data shown in this report include the 50 States, the District of Columbia, Puerto Rico, and other outlying areas.

Provisions of the Law

The Medicare HI program pays for the reasonable costs of all covered inpatient services in a SNF for up to 100 days of inpatient care. The first 20 days in a SNF are reimbursed in full. For each of the remaining 80 days in each benefit period the patient pays a coinsurance amount equal to one-eighth of the current inpatient hospital deductible.

The requirements for covered services are as follows:

- The patient requires daily skilled nursing care or related rehabilitative services;

- A physician must certify that the patient needs such care and must order it;

- The care as a practical matter can only be provided on an inpatient basis in a SNF;

- The patient has had a medically necessary stay in a participating hospital for at least 3 consecutive days prior to this admission;

- The patient is admitted within a limited period, generally 14 days after he is discharged from the hospital;

- The patient is admitted for further treatment of a condition for which he was treated in the hospital; and

- A patient who has been discharged from a SNF may be re-admitted to a participating SNF within 14 days of his discharge without re-entering a hospital.

Definitions

Covered day of care—A day of inpatient skilled nursing care during which the services (determined to medically necessary by the Professional Standards Review Organization or the Utilization Review Committee) covered by Medicare were furnished to a person eligible for HI benefits. The day of discharge is not counted as a day of care.

Discharge—The formal release of a patient from a hospital. Discharges include persons who died during their hospitalization or were transfered to another hospital.

Reimbursement—Payments under the HI program which are shown in this Note are based on interim reimbursement rates reported on processed bills. The interim rates are established to reflect current costs as closely as possible. These are usually established as a per diem amount or as a percentage of total charges. Figures shown exclude amounts for which the patient is responsible such as deductibles, coinsurance, and changes for noncovered services. The final amount of reimbursement due under Medicare to each provider of medical services is determined after the end of the fiscal year on the basis of the providers' audited reasonable cost of operations.

Skilled nursing facility—An institution providing inpatient skilled nursing and restorative care services which has a transfer agreement with one or more participating hospitals, and meets specific regulatory certification requirements. The SNF must be certified under Medicare in order to be reimbursed for skilled nursing care services.

States—Refers to the State where the beneficiary is living, not the State where he or she receives services.

Table 1

Use of Skilled Nursing Facility Services by Medicare Hospital Insurance Beneficiaries: Number of Covered Discharges, Covered Days of Care, Covered Charges, and Reimbursement by Type of Beneficiary, 1969-77

Calendar Year	Covered Discharges[1]	Covered Days of Care		Covered Charges			Reimbursement			
		Total (in thousands)	Per Discharge	Amount (in thousands)	Per Discharge	Per Day	Amount (in thousands)	Percent of Covered Charges	Per Discharge	Per Day
				All Beneficiaries						
1969[2]	367,855	14,467	39.3	[3]	[3]	[3]	$277,278	[3]	$ 754	$19
1970[2]	277,420	9,901	35.7	[3]	[3]	[3]	200,294	[3]	722	20
1971[2]	237,768	7,230	30.4	[3]	[3]	[3]	164,676	[3]	693	23
1972[2]	218,013	5,837	26.8	[3]	[3]	[3]	140,832	[3]	646	24
1973	239,462	6,423	26.8	[3]	[3]	[3]	159,282	[3]	665	25
1974	270,822	7,401	27.3	$276,017	$1,019	$37	204,067	73.9	754	27
1975	260,390	6,840	26.3	296,566	1,139	43	203,252	68.5	781	29
1976	264,312	7,040	26.6	342,028	1,294	48	227,976	66.7	863	32
1977[4]	269,615	7,387	27.4	393,099	1,458	53	253,708	64.5	941	34
				Aged						
1969	367,855	14,467	39.3	[3]	[3]	[3]	277,278	[3]	754	19
1970	277,420	9,901	35.7	[3]	[3]	[3]	200,294	[3]	722	20
1971	237,768	7,230	30.4	[3]	[3]	[3]	164,676	[3]	693	23
1972	218,013	5,837	26.8	[3]	[3]	[3]	140,832	[3]	646	24
1973	237,247	6,372	26.9	[3]	[3]	[3]	157,743	[3]	665	25
1974	262,812	7,185	27.3	266,601	1,014	37	197,394	74.0	751	27
1975	252,143	6,618	26.2	285,168	1,131	43	195,610	68.6	776	29
1976	255,640	6,808	26.6	328,715	1,286	48	219,415	66.8	858	32
1977[4]	260,751	7,145	27.4	377,567	1,448	53	243,802	64.6	935	34
				Disabled						
1973	2,215	51	23.0	[3]	[3]	[3]	1,539	[3]	695	30
1974	8,010	216	27.0	9,416	1,176	44	6,673	70.9	833	30
1975	8,247	222	26.9	11,398	1,382	51	7,642	67.0	927	34
1976	8,672	232	26.7	13,313	1,535	57	8,561	64.3	987	37
1977[4]	8,864	249	28.1	15,521	1,751	62	9,795	63.1	1,105	39

[1] Includes SNF discharges with at least one day of covered care under Medicare. Excludes stays for beneficiaries who have exhausted their SNF benefits and for whom no discharge record was received.

[2] Prior to 1973, services were covered only for beneficiaries aged 65 and over. Effective July 1, 1973, HI benefits were extended to persons under 65 years of age who were entitled to cash benefits for not less than 24 consecutive months under the Disability Insurance Program and to persons with End-Stage Renal Disease (ERSD).

[3] Covered charges not available for calendar years 1969-73.

[4] Preliminary estimates.

Table 2
Use of Skilled Nursing Facility Services by Aged Medicare Hospital Insurance Beneficiaries: Number of Covered Discharges, Covered Days of Care, Covered Charges, and Reimbursement by Region, Division and States, 1976

Area of Residence	Covered Discharges[1]	Covered Days of Care		Covered Charges			Reimbursement			
		Total (in thousands)	Per Discharge	Amount (in thousands)	Per Discharge	Per Day	Amount (in thousands)	Percent of Covered Charges	Per Discharge	Per Day
All Areas	255,640	6,808	26.6	$328,715	$1,286	$48	$219,415	66.8	$ 858	$32
United States	255,174	6,797	26.6	328,035	1,286	48	218,972	66.8	858	32
Northeast	71,491	2,082	29.1	111,324	1,557	53	74,715	67.1	1,045	36
North Central	65,876	1.895	28.8	87,469	1,328	46	56,562	64.7	859	30
South	51,768	1,479	28.6	60,760	1,174	41	40,729	67.0	787	28
West	66,039	1,342	20.3	68,482	1,037	51	46,966	68.6	711	35
New England	22,791	614	26.9	32,589	1,430	53	22,165	68.0	973	36
Maine	2,127	56	26.4	3,450	1,622	61	2,353	68.2	1,106	42
New Hampshire	2,075	58	27.9	2,766	1,333	47	1,895	68.5	913	33
Vermont	1,121	30	26.4	1,227	1,095	41	790	64.4	705	27
Massachusetts	7,758	237	30.5	16,388	2,112	69	10,997	67.1	1,417	46
Rhode Island	2,458	49	20.0	2,297	934	46	1,528	66.5	621	31
Connecticut	7,252	184	25.4	6,461	891	35	4,603	71.2	635	25
Middle Atlantic	48,700	1,468	30.2	78,735	1,617	53	52,550	66.7	1,079	36
New York	21,381	656	30.7	40,823	1,909	62	28,391	69.6	1,328	43
New Jersey	10,589	316	29.8	15,999	1,511	50	10,095	63.1	953	32
Pennsylvania	16,730	496	29.6	21,913	1,310	44	14,064	64.2	841	28
East North Central	48,205	1,427	29.6	62,936	1,306	44	39,868	63.4	827	28
Ohio	16,194	496	30.7	23,428	1,447	47	14,634	62.5	904	29
Indiana	5,709	166	29.1	6,450	1,130	38	3,961	61.4	694	24
Illinois	13,325	361	27.1	15,113	1,134	41	9,835	65.1	738	27
Michigan	10,555	328	31.0	15,059	1,427	45	9,642	64.0	914	29
Wisconsin	2,422	75	31.1	2,885	1,191	38	1,797	62.3	742	24
West North Central	17,671	468	26.5	24,533	1,388	52	16,694	68.0	945	36
Minnesota	4,998	130	26.1	7,135	1,428	54	4,913	68.8	983	38
Iowa	3,178	74	23.4	3,665	1,153	49	2,717	74.2	855	36
Missouri	4,904	142	28.9	8,015	1,634	56	5,182	64.7	1,057	36
North Dakota	344	9	25.9	424	1,232	47	283	66.8	823	32
South Dakota	339	8	24.1	309	913	37	172	55.7	508	21
Nebraska	1,724	47	27.0	2,267	1,315	48	1,606	70.8	931	34
Kansas	2,184	58	26.5	2,718	1,245	46	1,821	67.0	834	31
South Atlantic	31,790	957	30.1	36,543	1,150	38	23,828	65.2	750	25
Delaware	286	10	35.8	363	1,268	35	205	56.4	715	20
Maryland	2,626	82	31.1	3,507	1,336	42	2,351	67.0	895	29
Dist. of Columbia	340	11	31.7	426	1,254	39	275	64.4	808	25
Virginia	1,947	62	31.8	2,883	1,481	46	1,916	66.5	984	31
West Virginia	1,019	34	33.5	1,448	1,421	42	923	63.7	905	27
North Carolina	5,157	205	29.7	6,991	1,356	34	4,554	65.2	883	22
South Carolina	1,906	68	35.4	1,914	1,004	28	1,047	54.7	549	16
Georgia	2,843	63	22.2	2,556	897	40	1,691	66.2	595	27
Florida	15,666	423	27.0	16,455	1,050	38	10,867	66.0	694	26

(continued)

Table 2 (cont'd)

Use of Skilled Nursing Facility Services by Aged Medicare Hospital Insurance Beneficiaries: Number of Covered Discharges, Covered Days of Care, Covered Charges, and Reimbursement by Region, Division and States, 1976

Area of Residence	Covered Discharges[1]	Covered Days of Care		Covered Charges			Reimbursement			
		Total (in thousands)	Per Discharge	Amount (in thousands)	Per Discharge	Per Day	Amount (in thousands)	Percent of Covered Charges	Per Discharge	Per Day
East South Central	11,131	277	24.9	11,503	1,033	41	7,715	67.1	693	28
Kentucky	4,179	118	28.3	4,771	1,142	40	3,004	63.0	719	25
Tennessee	2,312	62	26.7	2,872	1,242	46	2,128	74.1	920	34
Alabama	4,098	84	20.4	2,967	724	35	2,081	70.1	508	25
Mississippi	542	14	25.2	892	1,645	65	502	56.4	927	37
West South Central	8,847	244	27.6	12,714	1,437	52	9,185	72.2	1,038	38
Arkansas	559	13	23.5	666	1,191	50	441	66.3	790	34
Louisiana	1,444	45	31.1	2,150	1,489	47	1,354	63.0	938	30
Oklahoma	1,690	36	21.6	2,389	1,414	65	1,889	79.0	1,118	52
Texas	5,154	150	29.1	7,509	1,457	50	5,502	73.3	1,067	37
Mountain	10,059	224	22.3	9,874	982	44	6,595	66.8	656	29
Montana	857	22	26.2	707	825	31	443	62.7	517	20
Idaho	865	18	21.1	508	587	27	340	66.9	393	18
Wyoming	195	4	21.0	128	656	31	75	58.9	386	18
Colorado	2,951	56	18.8	2,872	973	51	1,998	69.6	677	36
New Mexico	280	8	29.1	507	1,812	62	300	59.0	1,070	37
Arizona	2,830	70	24.7	3,266	1,154	46	2,118	64.8	748	30
Utah	1,028	23	22.5	947	922	41	710	75.0	691	31
Nevada	1,053	23	21.6	940	892	41	611	65.0	580	27
Pacific	55,980	1,118	20.0	58,608	1,047	52	40,371	68.9	721	36
Washington	7,534	144	19.2	5,867	779	40	4,007	68.3	532	28
Oregon	4,294	101	23.6	4,708	1,096	46	3,229	68.6	752	32
California	43,151	845	19.6	46,581	1,079	55	32,170	69.1	746	38
Alaska	19	[2]	23.0	27	1,420	61	19	69.8	991	43
Hawaii	982	27	27.2	1,425	1,451	53	945	66.3	963	35
Other Outlying Areas	466	11	23.8	680	1,459	61	443	65.2	951	40
Puerto Rico	418	10	23.2	610	1,460	62	401	65.8	960	41
Other	48	1	29.2	70	1,414	48	42	60.6	856	29

[1] Includes SNF discharges with at least one day of covered care under Medicare. Exludes Benefits-Exhausted stays without record of discharge.

[2] Quantity more than 0 but less than 500.

Health Care Financing Notes

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U.S. Department of
Health, Education, and Welfare
Health Care Financing Administration
HEW Publication No (HCFA) 03021